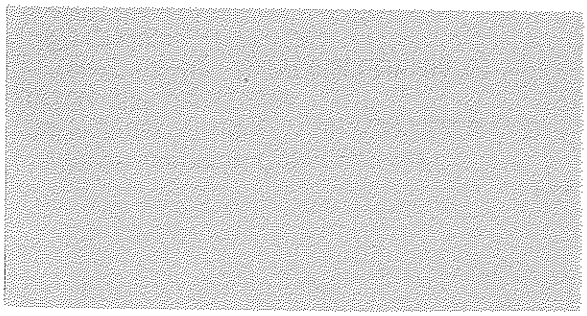
Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

HEALTHTRUST LLC
PO BOX 890008
HOUSTON TX 77289



Respondent Name
ACE AMERICAN INSURANCE CO

Carrier's Austin Representative Box
Box Number 15

MFDR Tracking Number
M4-12-0783-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "HealthTrust provided an 8 hour per day rehabilitation chronic pain management program to the above described patient. This service was preauthorized and billed appropriately to the carrier. The carrier made a partial payment of $400.00 on each date of service listed above, but has not made additional payments as would be the result of a MAR settlement."

Amount in Dispute: $13,920.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider is seeking supplemental reimbursement for Chronic Pain Management sessions that were authorized by the ESIS UR department. The carrier stands by its partial reimbursement for pain management sessions related to the claimant's physical trauma. However, the claimant was also receiving treatment for the primary diagnosis of adjustment Reaction—Mixed Emotion. This is not an accepted diagnosis of the carrier...the preauth Request indicating the primary diagnosis of Adjustment Reaction—Mixed Emotion, as well as the EOBs indicating body part mismatch and extent of injury denials."

Response Submitted by: ESIS South Central WC Claims PO Box 6563 Scranton, PA 18505-6563

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 06, 2010 through February 7, 2011	97799-CP	$13,920.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 sets forth general provisions regarding dispute of medical bills.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §141.1 sets out the procedures for requesting and setting a Benefit Review Conference.
4. 28 Texas Administrative Code §124.2 relating to Carrier Reporting and Notification Requirements
5. This request for medical fee dispute resolution was received by the Division on November 7, 2011.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated January 4, 2010, January 6, 2011, January 21, 2011, February 8, 2011, March 25, 2011 and March 29, 2011.
   - (W1) Workers compensation State Schedule Adjustment
   - (150) Payment adjusted because the payer deems the information submitted does not support this level of service.
   - (219) Based on extent of injury.
   - This bill was reviewed for ESIS treatment parameters. (MT38)
   - CV: MEDICAL DOCUMENTATION PROVIDED DOES NOT SUPPORT THE SERVICE (OR LEVEL OF SERVICE) BILLED. (V123)
   - Body Part mismatch (K304)

Issues

1. Was the request for medical fee dispute resolution filed in accordance with 28 Texas Administrative Code §133.305 and §133.307?
2. Are the disputed services eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307?

Findings

1. 28 Texas Administrative Code §133.307 (2)(D) if the carrier has raised a dispute pertaining to liability for the claim, compensability, or extent of injury, in accordance with 28 Texas Administrative Code §124.2 of this title (relating to Carrier Reporting and Notification Requirements), the request for medical fee dispute resolution will be held in abeyance until those disputes have been resolved by a final decision of the commission.
2. The appropriate dispute process for unresolved issues of compensability, extent and/or liability requires filing for a Benefit Review Conference pursuant to 28 Texas Administrative Code §141.1 prior to requesting medical fee dispute resolution. Review of the submitted documentation finds that there are unresolved issues of compensability, extent and/or liability for the same service(s) for which there is a medical fee dispute. No documentation was submitted to support that the issue(s) of compensability, extent and/or liability have been resolved prior to the filing of the request for medical fee dispute resolution.
3. The requestor has failed to support that the disputed services are eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307.

Conclusion

For the reasons stated above, the requestor has failed to establish that the respondent's denial of payment reasons concerning liability for the injured employee's workers' compensation claim, compensability of that claim, and/or extent-of-injury issues with that claim have been resolved through the required dispute resolution process as set forth in Texas Labor Code Chapter 410 prior to the submission of a medical fee dispute request for the same services. Therefore, medical fee dispute resolution staff has no authority to consider and/or order any payment in this medical fee dispute. As a result, no amount is ordered.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Laura Campbell — Signature

Laura Campbell — Medical Fee Dispute Resolution Officer

February 23, 2012 — Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.